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No. 05-260

Supreme Court, U.S.
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IN THE

Supreme Court of the United States

JOEL SEREBOFF AND MARLENE SEREBOFF,
Petitioners,

v.

MID ATLANTIC MEDICAL SERVICES, INC.,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

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BRIEF *AMICUS CURIAE* OF THE NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS IN SUPPORT OF RESPONDENT

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v.

MID ATLANTIC MEDICAL SERVICES, INC.,
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BRIEF *AMICUS CURIAE* OF THE NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS IN SUPPORT OF RESPONDENT

IDENTITY AND INTEREST OF THE NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS

The National Coordinating Committee for Multiemployer Plans ("NCCMP") is a nonprofit, tax-exempt organization that has participated for over a quarter of a century in the development of the law applicable to employee benefit plans.[1] The NCCMP's primary purposes are to assure an

[1] Pursuant to Rule 37.6 of the Rules of this Court, the undersigned hereby state that no counsel for Petitioners or Respondent authored any part of this brief. Moreover, no person or entity other than the NCCMP

environment in which multiemployer plans can continue their vital role in providing medical, pension and other benefits to working men and women, and to participate in the development of sound employee benefits legislation, regulations and policy affecting benefit plans.

The NCCMP is the only national organization devoted exclusively to protecting the interests of multiemployer plans by advocating on behalf of these plans in Congress, in the courts and in the regulatory process. Multiemployer plans provide benefits to tens of millions of American workers. Hundreds of multiemployer plans and related organizations, with a nationwide participant base located across the United States, are affiliated with the NCCMP. The plans affiliated with the NCCMP represent a majority of the participants in multiemployer plans throughout the nation and are representative of the multiemployer plan community generally. Affiliated plans are active in every major segment of the multiemployer plan universe, including the airline, building and construction, entertainment, food production, distribution and retail sales, health care, hospitality, mining, maritime, industrial fabrication, service, textile and trucking industries.

Because of this broad range of experience of the NCCMP's constituent organizations, the NCCMP believes that it is uniquely qualified to state the position of the trustees of such plans. The NCCMP and its constituent groups have a strong interest in supporting the decision below, to ensure that multiemployer plans continue to have an effective, efficient and uniform equitable remedy available to them in the federal courts to recover amounts due to the plans. Both Petitioners and Respondent have consented to the filing of this amicus brief, as is evidenced by letters of consent that have been filed with the Court.

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made a monetary contribution to the preparation or submission of this brief.

INTRODUCTION

The Court's decision in *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002), has had a devastating effect on benefit plans in general, and on health benefit plans in particular. Prior to the Court's decision in *Great-West*, beneficiaries routinely, and voluntarily, agreed on how and under what conditions they would satisfy a benefit plan's equitable right to a share of payments received from responsible tortfeasors. The vast majority of third party recovery cases were resolved efficiently and fairly. In the rare case when there was a disagreement over the amount or fairness of the reimbursement demanded, the beneficiary and the benefit plan could negotiate a mutually agreeable resolution, or if no agreement could be reached, request that the federal courts resolve the matter in a uniform manner. The federal courts proved to be very responsive to claims by beneficiaries that benefit plans were unfairly asserting an equitable right, and created appropriate safeguards. *See, e.g., Cagle v. Bruner*, 112 F.3d 1510, 1520-21 (11th Cir. 1997) (applying make-whole doctrine as a default interpretive principle to reduce reimbursement rights); *Waller v. Hormel Foods Corp.*, 120 F.3d 138, 141 (8th Cir. 1987) (recognizing common fund doctrine to reduce reimbursement rights).

After *Great-West*, beneficiaries, like the Sereboffs in this case, would accept health benefits from plans and then adopt a "come and get us if you can" response to the legitimate assertion that a benefit plan had an equitable claim to a share of payments recovered from third parties. Enforcing an equitable right to reimbursement has become increasingly complex and expensive for benefit plans because many beneficiaries simply refuse to honor the obligation to reimburse benefit plans. The NCCMP submits this brief to urge the Court to affirm the decision below, and leave to multiemployer plans the remaining narrow, but extremely

important, equitable remedy under § 502(a)(3) of the Employee Retirement Income Security Act of 1974. 29 U.S.C. § 1132(a)(3).

SUMMARY OF THE ARGUMENT

The Court of Appeals properly held that Mid Atlantic's equitable claim for constructive trust or equitable lien under § 502(a)(3) of ERISA was proper because it sought to enforce the terms of its plan through a remedy that has traditionally been available in equity. The settlement funds in dispute were specifically identifiable, belonged in good conscience to Mid Atlantic, and were still within the possession of the Sereboffs. The lower court's decision, therefore, followed the Court's holding in *Great-West* and should be affirmed. The narrow equitable remedy asserted by Mid Atlantic is crucial for benefit plans to obtain a portion of payments that rightfully belong to the plans in a wide range of contexts. The lower court's decision also has the effect of protecting valuable medical benefits provided to beneficiaries, which will be lost if plans have no effective method to assert their equitable reimbursement rights. Finally, the decision below also recognizes Congress's objective in enacting ERISA to spare benefit plans the needless additional expense and uncertainty of state court remedies.

ARGUMENT

I. RECOVERY FROM THIRD PARTY LIABILITY PAYMENTS IS NOT THE ONLY CIRCUMSTANCE IN WHICH A RESTRICTION OF AVAILABLE REMEDIES WILL OPERATE TO HARM BENEFIT PLANS.

The Petitioners and Amicus Association of Trial Lawyers of America place the question presented to the Court exclusively in the context of reimbursement and subrogation from payments obtained from tortfeasors. Reimbursement

claims are characterized as leading to "devastating consequences" or "harsh results." Pet'r Br. at 34; Br. of Amicus Curiae the Ass'n of Trial Lawyers of America at 17-19. These extreme characterizations overlook the facts presented by the Petitioners' own third party recovery at issue in this case: Petitioners recovered $750,000.00 from the responsible tortfeasors and Mid Atlantic claimed an equitable right to a share of that recovery in the amount of $74,869.37. *Mid At. Med. Servs, LLC v. Sereboff*, 407 F.3d 212, 214-215 (4th Cir. 2005.) Reimbursement under the facts presented in this case can hardly be characterized as "devastating" or "harsh." In any event, a narrow equitable remedy of a constructive trust or equitable lien is necessary for benefit plans to obtain recoveries in all kinds of situations, not just reimbursement and subrogation.

A. An equitable remedy is necessary for all types of recoveries, not only subrogation and reimbursement.

The Petitioners' exclusive focus on reimbursement and subrogation overlooks the broader impact the Court's ruling will have on the orderly administration of benefit plans. In addition to reimbursement claims involving payments from responsible tortfeasors, benefit plans of all kinds, medical and pension, encounter situations where money must be recovered in equity. Overpayments from benefit plans can occur in a myriad of factual scenarios. For example, a benefit plan paying a death benefit may mistakenly pay the wrong individual, or a payment may be obtained by an individual through fraud. Commonly, a pension benefit plan is not notified immediately of a pensioner's death and that benefits should be discontinued. As a result, monthly pension benefit payments are erroneously deposited electronically into the deceased pensioner's account. Sometimes, a benefit plan simply miscalculates the amount of a benefit, and overpays a participant or beneficiary in error. In all of these situations,

benefit plans must have an equitable right to recover the overpayment from funds held by the beneficiary.

Prior to the Court's decision in *Great-West*, the lower federal courts had no difficulty creating an unjust enrichment remedy as part of federal common law, permitting benefit plans to seek restitution against third parties who wrongfully or mistakenly received money from an ERISA plan. *See, e.g., Heller v. Fortis Benefits Ins. Co.*, 142 F.3d 487, 495 (D.C. Cir. 1998); *Luby v. Teamsters Health, Welfare & Pension Trust Funds*, 944 F.2d 1176, 1186 (3rd Cir. 1991); *Blue Cross & Blue Shield of Ala. v. Weitz*, 913 F. 2d 1544, 1548-49 (11th Cir. 1990); *Provident Life & Accident Ins. Co. v. Waller*, 906 F. 2d 985, 994 (4th Cir. 1990). After the Court's decision in *Great-West*, however, the lower courts began to question whether an ERISA benefit plan could sue under § 502(a)(3) to recover benefits in any context. *See, e.g., Coop. Benefit Administrators, Inc. v. Ogden*, 367 F.3d 323 (5th Cir. 2004) (holding benefit plan had no remedy under § 502(a)(3) to recover pension benefits advanced to participant waiting for social security disability payments to begin); *Honolulu Joint Apprenticeship & Training Comm. v. Foster*, 332 F.3d 1234 (9th Cir. 2003) (holding benefit plan had no remedy under § 502(a)(3) to recover costs of apprenticeship training); *Trustees of the AFTRA Health Fund v. Biondi*, 303 F.3d 765, 771 (7th Cir. 2002) (noting district court's dismissal of benefit plan's action under § 502(a)(3) to recover fraudulently obtained benefit payments). The very narrow equitable remedy of constructive trust or an equitable lien as permitted by the court below is vital to benefit plans in any context in which they must recover plan assets from third parties.

B. Hardships caused by state legislation or incomplete remedies are not the necessary result of benefit plans' reimbursement and subrogation provisions.

The Petitioners' and Amicus Curiae in Support of Petitioners' characterization of benefit plans' equitable reimbursement remedies as harsh and unfair overlooks the "commonplace economic calculus" present in every personal injury lawsuit. *Kress v. Food Employers Labor Relations Ass'n & United Food & Commercial Workers Health & Welfare Fund*, 391 F.3d 563, 570 (4th Cir. 2004). According to the Fourth Circuit:

> Attorneys considering taking a case on contingency commonly factor the likelihood of success and the magnitude of recovery into their decision. Many tort claims involve considerable risk and insufficient reward. Attorneys, however, carefully screen these claims and reject a large portion, including most denominated as high risk. . . . If the participant and his attorney conclude that private litigation will not produce a sufficient recovery to make the litigation worthwhile, they need not bring the case.

Id. (citation and quotation omitted.) Thus, harsh results are not caused by benefit plans enforcing a right to reimbursement and subrogation. Instead the "unfairness" is often an inherent part of the litigation process which has been described, in this context, as being "like a lottery ticket." *Cutting v. Jerome Foods, Inc.*, 993 F.2d 1293, 1294 (7th Cir. 1993). In fact, far from creating hardships, the availability of subrogation and reimbursement serves to shift the risk of an uncertain recovery onto the *benefit plan* and away from the beneficiary. *Id.* at 1297. This is because by advancing medical benefits to the beneficiary in anticipation of a possible equitable claim to proceeds obtained in the future, the "lottery ticket" of uncertain payment for medical expenses

is transferred from the beneficiary to the benefit plan. *Id.* at 1298.

II. THE DECISION BELOW PROTECTS BENEFICIARIES' ABILITY TO OBTAIN IMMEDIATE MEDICAL BENEFITS WHEN INJURIES ARE CAUSED BY THIRD PARTIES.

Self-funded multiemployer benefit plans are not obligated by any law to pay medical benefits when a beneficiary is injured by a third party. The result of the position advanced by Petitioners eliminating benefit plans' ability to enforce equitable claims to a portion of compensation received by tort victims will be to discourage the payment of such benefits. Thus, beneficiaries will be left with no medical benefit coverage at a time when they need it most, after an unexpected accident caused by a tortfeasor.

Although ERISA establishes a comprehensive regulatory scheme for benefit plans in general, it does not mandate any minimum substantive content for welfare benefit plans in particular. *See, e.g., Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 91 (1983); *Hamilton v. Air Jamaica, Ltd.*, 945 F.2d 74, 78 (3rd Cir. 1991). As a result, employers "have large leeway to design disability and other welfare plans as they see fit." *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 833 (2003). In *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 732 (1985), the Court held that ERISA "does not regulate the substantive content of welfare-benefit plans." ERISA generally leaves it to plan sponsors "to adopt, modify, or terminate welfare plans." *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995); *see also Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 511 (1981).

The vast majority of multi-employer plans affiliated with the NCCMP have not agreed to pay medical benefits for injuries caused by third parties. The written plans commonly provide that benefits are not payable if a sickness or injury is

the responsibility of a third party. However, recognizing the need of beneficiaries to pay for extraordinary medical expenses in the event of unexpected sickness and injuries, benefit plans often agree to advance benefits. That advance, however, is conditioned on the beneficiary's promise to honor the benefit plan's equitable right to a portion of compensation if and when the beneficiary obtains compensation from the responsible third party. *See, e.g. Kress*, 391 F.3d at 565 (plan refused to pay benefits for injuries from auto accident when beneficiary refused to acknowledge equitable reimbursement right); *Copeland Oaks Employee Benefit Plan v. Haupt*, 209 F.3d 811, 812 (6th Cir. 2000) (same); *Cagle v. Bruner*, 112 F.3d 1510, 1513 (11th Cir. 1997) (same).

The terms of a typical plan of benefits are illustrated by the plan considered by the Fourth Circuit in *Kress*:

> Waiting for a third party to pay for these injuries may be difficult. Recovery from a third party can take a long time (you may have to go to court), and your creditors will not wait patiently. Because of this, as a service to you, the Fund will pay your (or your eligible dependent's) expenses based on the understanding that you are required to reimburse the Fund in full from any recovery you or your eligible dependent may receive, no matter how it is characterized. This process is called "subrogation." . . . . The Fund extends benefits to you and your dependents only as service to you. The Fund must be reimbursed if you obtain any recovery from another person or entity's insurance coverage.

Kress, 391 F. 3d at 566. Thus, far from having contracted to bear the risk associated with the costs of injuries caused by third parties, benefit plans typically expressly disavow any obligation to pay benefits under those circumstances.[2]

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[2] Amicus American Trial Lawyers Association argues that restricting benefit plans' ability to enforce subrogation provisions is appropriate because beneficiaries are merely receiving the benefits to which they are

However, recognizing the difficult circumstances presented to beneficiaries, benefit plans typically agree to advance medical costs to tide over beneficiaries in difficult times, *but only if* the beneficiary promises to reimburse the benefit plan later. As emphasized by the Fourth Circuit, these plan provisions

> broadened rather than narrowed the options of Fund participants. Nothing required [the beneficiary] to accept the subrogation option; he was free to reject it and commence litigation at once, with no obligations whatever to the Fund. But if he did accept the Fund's offer, and then recovered in tort, it was not wrongful for the Fund to seek to recoup this expenditure to provide for future participants who may find themselves in similarly straitened circumstances. The Fund "must serve the best interests of all Plan beneficiaries, not just the best interest of one potential beneficiary."

Kress, 391 F.3d at 570-71 (footnote omitted) (*quoting Ellis v. Metro. Life Ins. Co.*, 126 F.3d 228, 234 (4th Cir. 1997)). It is the voluntary nature of these advanced payments that clearly establishes the need for an *equitable* remedy of reimbursement, as opposed to the legal remedy of a breach of contract.

If the Court further restricts benefit plans' ability to obtain a constructive trust or equitable lien under these circumstances, as argued by Petitioners, the result will not be a greater recovery by beneficiaries in personal injury lawsuits. Instead, benefit plans likely will respond by simply not ad-

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contractually entitled in the first place. Amicus Br. at 25-26. Thus, according to Amicus, because benefit plans have "accepted payment for coverage of the beneficiary's medical expenses," there is no policy justification to require beneficiaries to reimburse medical plans out of tort recoveries from third parties. Amicus Br. at 31-32. As detailed by the plan language quoted above, this argument ignores that many benefit plans do not, in fact, contract to bear the risk to pay medical benefits when injuries or a sickness are caused by a third party.

vancing these payments in the first place, leaving beneficiaries to deal with medical bills, creditors and delays on their own through the uncertain and lengthy process of personal injury lawsuits. This cannot be good public policy.

Eliminating benefit plans' equitable remedies as argued by Petitioner will create hardship for the beneficiaries in another form as well. Currently, as described above, plans typically advance benefits to beneficiaries in their time of need, based on a promise to reimburse in the event that a future recovery is obtained. In some cases, at a point of time far in the future, the beneficiary may eventually recover a payment from the tortfeasor and be required to reimburse the plan. However, in far more common situations, the beneficiary decides not to pursue an action against the responsible tortfeasor, or based on the uncertainties and expense of litigation agrees to a settlement which is less than full compensation. In these common scenarios, the beneficiary retains the benefit of having had his medical expenses paid on his or her behalf. This benefit will be lost if benefit plans stop advancing benefits because they cannot enforce an equitable claim of reimbursement.

III. THE STATE COURTS DO NOT OFFER UNIFORM OR EFFECTIVE REMEDIES TO BENEFIT PLANS.

Petitioners' suggestion that benefit plans really do not need an equitable remedy pursuant to § 502(a)(3) of ERISA because they have other adequate options, such as intervening in state court lawsuits, should be rejected. As an initial matter, the Petitioners' suggestion that benefit plans should intervene in state court tort actions completely ignores the fact that "the vast majority of tort actions end in settlement." Amicus Br. the American Trial Lawyers Association at 17. Therefore, there will usually not be a state court lawsuit in which to intervene in the first place.

The Petitioners' suggestion that benefit plans have adequate remedies in the various state court jurisdictions also runs contrary to Congress's explicit purpose to obtain uniformity for benefit plans when it enacted ERISA. The purpose of the Act was to provide plans a uniform set of administrative procedures, rather than make them comply with a different set of procedures for processing claims and disbursing benefits in each state and subdivision. *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987); *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656 (1995) (*quoting Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990).) When applying this Congressional purpose to subrogation and reimbursement provisions in particular, the Court held that the "application of differing state subrogation laws to plans would therefore frustrate plan administrators' continuing obligation to calculate uniform benefit levels nationwide." *FMC Corp. v. Holliday*, 498 U.S. 52, 60 (1990). *See also* 29 U.S.C. § 1144 (establishing the preemption of state laws which related to ERISA benefit plans.)

Intervention in state court tort lawsuits does not present a uniform set of procedures to address benefit plans' equitable rights of reimbursement and subrogation. If a beneficiary's tort action is pending, and assuming that the benefit plan is even aware of the lawsuit, benefit plans will be required to become expert in the intricacies of each state's tort recovery laws. They also will be required to monitor each jurisdiction's peculiar court rules, and they will be required to hire local attorneys to protect the benefit plans' interests. In addition, these state court actions will be located in any jurisdiction in which a benefit plan's beneficiary might travel or reside. As such, the need to defend the benefit plan's interests in far-flung jurisdictions will increase the plan's administrative expenses. The result of losing a uniform equitable remedy in the federal courts will be increased administrative costs to the benefit plans, and a concomitant

reduction in assets available to pay benefits for the plans' participants and beneficiaries.

Benefit plans frequently encounter situations, without the ability to intervene in the beneficiary's state tort lawsuit, in which they must take action to enforce equitable subrogation rights. In these situations a uniform equitable remedy is required to enforce the terms of the plan. Tort victims who have received payments from the responsible tortfeasors, and their attorneys, often do not act in good faith with regard to their obligations.[3]

An illustrative situation was presented to the district court in *HCA v. Clemmons*, 162 F. Supp. 2d 1374 (M.D. Ga. 2001). The beneficiary obtained medical benefits to pay for expenses related to her injury in an automobile accident. The beneficiary accepted the benefits from the plan with the understanding that the plan would later assert an equitable right of reimbursement in the event that she received a recovery from the responsible tortfeasor. *Id.* at 1376. The

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[3] Arguments based on the harshness of results in some subrogation cases ignores the obvious fact that recoveries from responsible tortfeasors, whether through a judgment or settlement, are universally intended to compensate the injured individual for the costs of treating injuries caused by the wrongdoing of the tortfeasor. *Mid At Med Servs, Inc v Do*, 294 F. Supp. 2d 695, 701 (D. Md. 2003) (holding that if a tort victim obtains a recovery that does not otherwise specify the nature of compensation, "it may be presumed that said recovery is intended to cover medical expenses"). In *Bunting Bearings Corp. v Miller*, 139 F. Supp. 2d 858 (N. D. Ohio 2001), the district court took judicial notice of the fact that "personal injury lawyers in personal injury cases typically assess the settlement value of a case on a multiple of the 'specials'." *Id.* at 859. The term "specials" usually means the medical expenses and lost wages incurred as a result of an injury. *Id.* These observations demonstrate why benefit plans' right to a portion of settlement proceeds obtained from responsible tortfeasors is appropriate because the settlement proceeds were intended to compensate the beneficiary for the cost of medical care in the first place.

benefit plan also placed the responsible tortfeasor's insurance company on notice of its reimbursement claim, and the insurance company agreed to add the benefit plan's name on any subsequent settlement checks. *Id.* at 1377.

Notwithstanding the fact that both the beneficiary and the responsible tortfeasor's insurer were aware of the benefit plan's claim, the two made a secret agreement to circumvent the benefit plan's equitable interest in the settlement. Rather than include the benefit plan on the settlement check, the insurance company paid the settlement proceeds directly to the tort victim without adding the plan's name on the check. *Id.* The insurance company agreed to circumvent the benefit plan's equitable claim in exchange for the beneficiary's promise to indemnify the insurance company. *Id.* Thereafter, in the absence of a tort lawsuit in which to intervene, the benefit plan was forced to bring an action against the beneficiary to obtain an equitable remedy. This is an example of how, without the very narrow equitable remedy left to it under § 502(a)(3), a benefit plan would not otherwise be able to enforce its rights in the federal courts. That result is not consistent with Congress's intention in enacting ERISA to create a uniform set of administrative procedures under which benefit plans may operate. *Fort Halifax Packing Co.*, 482 U.S. at 9.

Of course, the existence of a viable state court cause of action cannot be assumed, as there is no guarantee that such an action will be permitted by every state court. In *Great-West Life & Annuity Ins. Co. v. Smith*, 180 F. Supp. 2d 1311 (M.D. Fl. 2002), another common situation is illustrated. The beneficiary accepted benefits from the plan to pay for expenses related to injuries caused in an automobile accident. The beneficiary's attorney negotiated a settlement with the responsible tortfeasor and, with full knowledge of the benefit plan's claim of reimbursement and subrogation, the attorney disbursed the settlement proceeds to the beneficiary (and no

doubt retained a contingency fee from the proceeds). *Id.* at 1313. The beneficiary and attorney refused to recognize the benefit plan's equitable claim to a portion of the settlement proceeds. The benefit plan was therefore required to protect its rights by bringing an action for equitable reimbursement against the beneficiary and attorney.

On a motion to dismiss, the district court ruled that the benefit plan properly sought equitable relief under § 502(a)(3) of ERISA. *Id.* However, the district court dismissed all of the plan's state court causes of action. *Id.* at 1313-14. This case demonstrates a situation where, if the Court accepts the Petitioners' argument that there should be no equitable remedy under § 502(a)(3), the benefit plan would have had no ability to enforce the terms of its plan of benefits and its equitable claim to a portion of the settlement. It was only through the very narrow equitable remedy of constructive trust that any relief was available to the benefit plan. If this narrowest equitable remedy is abolished by the Court overruling the decision of the court below, benefit plans may be left with no recourse to enforce their rights of reimbursement and subrogation. As discussed above, the absence of a remedy in this situation surely will result in benefit plans not advancing benefits for injuries caused by third parties. This outcome will place a burden on beneficiaries that is clearly greater than the "devastation" described by Petitioners when benefit plans seek reimbursement.

Forcing benefit plans to attempt to enforce equitable rights in the state courts also will result in the uneven payment of benefits to beneficiaries. This is because, depending on which jurisdiction is involved, some beneficiaries will be required to reimburse medical benefits out of payments from responsible tortfeasors. The net result for these beneficiaries will be that the plan does not pay benefits when third party liability is involved. Other beneficiaries will not be required to reimburse medical benefits out of settlement payments because state

court actions to enforce reimbursement and subrogation are prohibited in some jurisdictions. *See, e.g., Liberty Northwest Ins. Corp. v. Kemp*, 192 Ore. App. 181, 85 P.3d 871 (Ct. App.), *rev. denied*, 337 Ore. 34, 93 P.3d 71 (2004) (holding benefit plan's state breach of contract action for reimbursement preempted by ERISA), *but see Providence Health Plan v. McDowell*, 385 F.3d 1168, 1173 (9th Cir. 2004), *cert. denied*, 125 S. Ct. 1726 (2005) (disagreeing with conclusion of preemption). The resulting inconsistent benefit payments on a state-by-state basis, of course, is a situation Congress sought to avoid when it enacted ERISA. *FMC Corp.*, 498 U.S. at 60. Affirming the Fourth Circuit's ruling in this case, and preserving the very limited equitable remedy under § 502(a)(3), will avoid these state-by-state inconsistencies in benefit payments.

CONCLUSION

For the foregoing reasons, the NCCMP respectfully urges the Court to affirm the decision below.

Respectfully submitted,

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